



ADAD-PN4 Revocation of Authorization

Read this information first

You should complete this form if you no longer want the department to use or disclose your medical information to any or all of the persons listed on your previously filed authorization, Form ADAD-PN3, Authorization for Use or Disclosure of Medical Information.

If you need additional assistance, please call **1 800 624-2459** (8 a.m. to 5 p.m. weekdays) or **1 800 544-5304** our TDD (telecommunications device for the deaf).

Mail this form to: Pharmaceutical Assistance Section, Illinois Department of Revenue, P.O. Box 19021, Springfield, IL 62794-9021.

Step 1: Complete the participant's or applicant's information

1 _____
Participant's or applicant's name

2

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Participant's or applicant's SSN

Step 2: Tell us whose authorization you want to revoke

3 Check this box if you want to revoke **all** authorizations. ☐

If you only want to revoke certain authorizations, write them on the lines below.

4 _____
Name

Address

City State ZIP

Phone

5 _____
Name

Address

City State ZIP

Phone

6 _____
Name

Address

City State ZIP

Phone

7 _____
Name

Address

City State ZIP

Phone

Step 3: Sign below

8 _____
Participant's, applicant's, or personal representative's signature

____ / ____ / ____
Month Day Year

9 _____
Personal representative's relationship to participant or applicant